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March 13, 2012

Statement
Of
Anthem Blue Cross and Blue Shield
On
HB 5487 An Act Concerning The Recommendations of the Small Business Healthcare Working Group and Claims Information To Be Provided By Insurers

Good afternoon Senator Crisco, Representative Megna and members of the Insurance and Real Estate Committee, my name is Christine Cappiello and I am the Director of Government Relations for Anthem Blue Cross and Blue Shield in Connecticut.

I appreciate the opportunity to speak on HB 5487. We respectfully request **rejection of HB 5487.** As we all are aware, the President signed into law significant legislation in 2010 that will dramatically change the way health insurance is purchased and consumed in this country, and HB 5487 includes several elements that are inconsistent with the federal Affordable Care Act (ACA)and will make it more difficult for the insurance industry to implement the ACA.

The insurance marketplace has already begun to conform to the ACA in areas like expanding parent's coverage to age 26 for their dependents to removal of lifetime caps. That transformation will culminate with the formation of health insurance exchanges, changes to the rules for the health insurance market, and a mandate to purchase insurance in 2014. HB 5487 seems to imply that those significant changes in the health insurance marketplace will not go into effect and seeks to addresses the concerns set forth in federal healthcare reform in a very different direction.

Allow me to expand on that last statement.

Connecticut was one of the first states in the nation to pass significant and meaningful small group health insurance reform and it did so back in the 1990s. Concepts like the reinsurance pool; community adjusted rating factors (these reflect differences in groups based on age, gender, geographic location, group size, industry and family composition); no pre-existing condition exclusion and guarantee issue in the group market are still not available in some states and can all be considered part of the basis for the federal ACA. All these things are important tools that the Connecticut Legislature passed in the 1990s to help small business owners and they did just that. In fact, any of these concepts will now become the law of the

land in 2014 for the rest of the country. The Connecticut Legislature should take a bow for passing those reforms more than 20 years ahead of the federal reform passed in 2010.

In addition to rating rules, there are other areas of HB 5487 that are inconsistent with the ACA:

- The ACA has reinsurance and risk adjustment which have not yet been defined, and thus it is premature for Connecticut to make changes to its reinsurance law.
- Rules for Associations have not yet been defined for 2014 and thus it is premature for Connecticut to make changes to how associations work relative to rating and pooling laws.
- HB 5487 sets a framework for price variation between products, but those rules have yet to come from the federal government as the ACA is implemented.
- It will be impossible for insurers to report the actuarial value for products 60 days following final federal regulations on the subject.

HB 5487 began by trying to address concerns expressed by small business owners across Connecticut. It is clear that providing health insurance for their employees is generally the single most expensive benefit given to their employees and is a tool for recruitment and retention of those employees. For that reason, cost and availability of health insurance are key issues.

The reason the Connecticut Legislature passed small group reform passed in the 1990s was to stabilize the premium rate swings in the small group market that were occurring and severely impacting small businesses ability to succeed with such volatility from year to year on their number one expense and it has done just that for many year. Proposals in HB 5487 like changing to pure community rating; and other provisions in the bill will dramatically impact those important initiatives.

Insurance rating rules must strike a critical balance between having a constraint on price differential relative to risk while still giving low-risk groups a reason to participate in the insurance market. If insurers cannot provide discounts for factors like age, there is little reason for younger groups to participate in the market, and thus rates increase for everyone. And while the ACA seeks to strike this balance by allowing a 3:1 age band, New York's small group market demonstrates how rules that are too tight can harm the marketplace. Similar to HB 5487, NY has "pure community rating" in the small group market. The result recently has been extreme volatility as younger and lower-risk groups leave the market, driving very large rate increases and carriers being forced to withdraw products from the market. Connecticut should not seek to replicate that volatility.

Health insurance serves several public policy goals: it enables consumers to spread the risk of health care expenses and provides them access to medical services that they might otherwise not be able to obtain. Because of the importance of health insurance to the general public

welfare, states have been regulating private health insurance companies and products since the late 19th century. State insurance regulation has sought to ensure initiatives like the best way to spread risk in order to provide that stability to employers.

I would also like to take a moment to speak about the provisions of the bill that allow for small employers to enter into the Healthcare Partnership program offered through the Comptroller's office. We believe, if you open the State of Connecticut employees benefit program to the small group market or any other marketplace, you initially will attract those groups that carry higher monthly claims expense. If their previously higher claims expense is due to higher utilization, more catastrophic illness, or difference in demographics than what is already in the Partnership/state employee pool, then these new entries threatens rate adequacy in the initial years and could threaten the viability of the pool in later years.

The goal of a group health insurance system is to provide access to quality healthcare benefits and the appropriate distribution of risk. A number of techniques are used to estimate the expected claims of a group. Items such as age, gender, location, type of industry, group financial strength, ease of administration, level of participation, prior persistency, current and future benefits, level of managed care and prior claims experience are used to develop an actuarially sound group rate. Accepting these principals, the expanded Connecticut Healthcare Partnership program that affords all access to the State of Connecticut's plan of benefits needs to create a rating model that aligns the risk associated with each group participating within the pool. Without the option to align risk, two things can occur. Rates for the entire pool could possibly be inadequate and groups with better risk could potentially seek insurance outside of the pool. Also, unanticipated change in enrollment among the plans within the program could create inappropriate funding in one of more of the plans. This could set up inadequate funding in the first year followed by significant rate increases for the pool upon renewal.

Premiums are only the mechanism for paying for the cost of health care. Premiums and how they are derived is the end of the chain of the delivery of healthcare. What is not addressed in HB 5487, nor frankly in federal healthcare reform, is the rising of the cost of the care that premiums are used to pay for. That is real issue for small businesses owners. Health plans are beginning to give consumers the tools to understand the cost of the medical care that they are about to consume with the hope that people will help a better appreciation for what that 80 cents on every medical dollar goes to. That is where the real debate needs to occur when looking at real meaningful reform.

Thank you for the opportunity to speak today and I welcome any questions you may have.